WAUKESHA COUNTY DEPARTMENT OF HEALTH AND HUMAN SERVICES
AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

I, the undersigned, hereby authorize the disclosure of the records and information specified below concerning :

_____ whose date of birth is: _____

by the Waukesha County Department of Health and Human Services (WCDHHS) to:

Individual/Agency: _____

Address: _____

_____

_____

TYPE OF INFORMATION TO BE RELEASED: ☐ Verbal ☐ Written

INFORMATION TO BE RELEASED: (Check applicable boxes)
Dates from: _____ **to:** _____

☐ Intake/Initial Assessment	*	____	☐ Staffing/Progress Notes	*	____	☐ HIV (AIDS)	*	____
☐ Psychiatric/Psychological Evaluations	*	____	☐ Medical Evaluations/ H & P / Records	*	____	☐ Laboratory Reports	*	____
☐ Social History	*	____	☐ Sexually Transmitted Disease	*	____	☐ Medications	*	____
☐ Treatment Plan/Reviews	*	____	☐ Education Evaluations/Records	*	____	☐ Discharge Summary	*	____
☐ Record Review								
☐ Other (Specify): _____							*	____

* Denotes Items That Were Released

This information is to be released from the following WCDHHS client/patient files/records:

☐ Adult Human Services ☐ Child/Family Human Services ☐ Public Health
☐ Alcohol and Other Drug Abuse (AODA) ☐ Mental Health

PURPOSE OF DISCLOSURE: (Check applicable categories)

☐ Continuity and Coordination of Care ☐ Insurance/Payment Concern ☐ Medical Care
☐ Educational Planning ☐ Legal Investigation or Action ☐ Personal

I understand that if the person and/or agency listed above are not governed by applicable federal and state laws and administrative codes, the confidential information disclosed as a result of this authorization may no longer be protected from further redisclosure without obtaining my authorization.

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATON:

I understand that I have the right to inspect or have a copy of the confidential information I have authorized to be used or disclosed by this authorization form. I understand that if I agree to sign this authorization, which I am not required to do, I must be provided with a signed copy of the form. I understand that I am under no obligation to sign this form and that the person and/or agency listed above who I am authorizing to use and/or disclose my information may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization. I understand written notification is necessary to cancel this authorization. To obtain information on how to withdraw my authorization, I may contact my WCDHHS staff providing/coordinating my services. I am aware that my withdrawal will not be effective as to uses and/or disclosures of my health information that the person and or agency listed above have already made in reference to this authorization.

EXPIRATION DATE: This authorization is good until the completion of active services with WCDHHS unless a specific date is entered here _____ or unless a written notice of revocation is submitted.

I have had an opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes. A copy of this authorization will be considered as valid as the original

PRINT NAME: _____

SIGNATURE PATIENT/LEGAL REP: _____ **DATE:** _____

Signature is that of the: ☐ Client/Patient ☐ Parent of Minor ☐ Legal Guardian ☐ Client/Patient's Representative

WITNESS: _____

ROUTING: White – Client/Patient File Pink – Client/Patient FM-6246-A Rev. 01/07